



Photograph by Bruno E. Mickleit

THE GEORGE ROBERT WHITE BUILDING
Massachusetts General Hospital

The George Robert White Building of the Massachusetts General Hospital

Nathaniel W. Faxon, M.D. '05, Director

In 1930 Mrs. Harriet J. Bradbury bequeathed to the Massachusetts General Hospital funds for the erection of a "building of major importance to the hospital" in memory of her brother, George Robert White. Delayed by the depression years, work on this building was begun on August 18, 1937. The dedication of the George Robert White Memorial Building took place on Ether Day, October 14, 1939.

The new building is fourteen stories high, of a light gray brick which closely resembles in tone the granite of the old Bulfinch Building. It is designed in clean cut masses and large finely proportioned window openings, without cornices or any form of ornamentation and by its size and simplicity it dominates and at the same time unifies the entire hospital group.

In plan the building is in the shape of a cross, the principal arm running North and South, the other East and West. This shape reduces the apparent bulk of the building and preserves the greatest amount of light and air to the older buildings around it.

The George Robert White Building has made it possible to assemble the scattered surgical wards and bring them under one roof, with the facilities they use. Similarly, it enables medical patients to be concentrated in the Bulfinch Building. The George Robert White Building and the Bulfinch Building will house most of the patients who do not enter the Phillips House or the Baker Memorial. This will represent a fundamental change in the arrangement of hospital facilities, a change which is expected to produce better care of patients.

The building is of fireproof construction and all materials have been selected to give long service with low maintenance cost. All ceilings are of sound deadening ma-

terial and are removable to allow servicing of pipes and electrical wiring. Kitchen and utility room equipment is largely of stainless steel. A pneumatic tube system with the central station adjacent to the Record Room provides quick transportation of records, messages and even medicine to any floor.

The basement contains kitchens for serving all patients in the General Hospital as well as doctors, nurses and employees, each group having a separate dining room. A pay cafeteria for employees and visitors to patients is also provided.

On the first floor is the Main Entrance to the Hospital with waiting rooms and Information Desk. Beyond this are the administrative offices and nursing offices. To one side of the Main Entrance is the Ambulance Entrance to the Accident Room and Emergency Ward.

The second floor is occupied entirely by the X-Ray Department serving the General Hospital and Out-Patient Department. A one million volt x-ray generator has been developed by the Massachusetts Institute of Technology, with the aid of a grant from the Godfrey M. Hyams Trust, and has been presented to the Massachusetts General Hospital for use in cancer therapy. This machine will be used also for the treatment of patients from the Phillips House and Baker Memorial Hospital.

The next two floors, 3 and 3-A, are for operating rooms. The third floor contains only operating, anesthesia and sterilizing rooms and admittance is restricted to doctors, nurses and others directly participating in operations. Floor 3-A provides overhead balconies for the viewing of operations by visiting physicians and medical students. Dressing rooms for staff, nurses and orderlies, a large surgical dressing

room or central supply room where all sterile supplies for the General Hospital will be made, and a teaching amphitheatre extending through two floors, seating 100 persons, are located on this floor. All operating rooms are air conditioned. From the central supply room, dumb waiter service goes to each floor so that sterile supplies, trays, instruments, etc., can be sent quickly when needed.

The fourth floor contains the offices of those members of the surgical staff on a full time basis and the research laboratories of this department.

The remaining eight floors are for patients, thus placing the wards well above surrounding buildings so that patients get a maximum of sunlight and air. The fifth floor with 52 beds is for orthopedic and fracture cases. The next four floors, the sixth, seventh, eighth, and ninth, are for patients with general surgical conditions. Each floor has 36 beds or a total of 144 beds for general surgical patients. In each east wing is a ward of 16 beds divided by partitions into four 4-bed units, while each west wing has a similar ward of 12 beds which may later be increased to 16 beds. Each southern wing provides six single rooms for the care of very sick patients. At the end of each wing is a large well lighted solarium.

The tenth floor of 27 beds is for urological patients and has two rooms for cystoscopies and minor operations.

The eleventh floor, also of 27 beds, is for the neurological and neurosurgical services, a combined service which experience during the past four years has shown to be advantageous.

The twelfth floor provides 17 single rooms for the isolation of patients who have developed contagious diseases while in the hospital or who need to be isolated because of their medical or surgical condition.

In the first story of the Pent House over the twelfth floor are housed the telephone switchboard and automatic telephones. The top story contains elevators, machinery and ventilating fans.

The total number of beds provided in the building is as follows:

Orthopedic and fracture beds	52
General surgical beds	144
Urological beds	27
Neurological, neurosurgical beds	27
Isolation Room	17
Emergency Ward	27
Total	294

The total capacity of the General Hospital will now be 469 beds; that of the Baker Memorial, 280, and the Phillips House, 101—a total of 850.

Graduate Training in Surgery at the Massachusetts General Hospital

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The physical rearrangement of the Surgical Services made possible by the George Robert White Building and the changes to be made in the Bulfinch Building for the Medical Services will add but 17 beds to the capacity of the Massachusetts General Hospital. The present policy of the hospital is to grow better but not bigger.

One of the major activities of the hos-

pital that will be materially strengthened is its educational program. No radical change is contemplated in the clinical clerkship, in fact, changes in the undergraduate curriculum must be initiated by the Medical School. The students, being an integral part of the personnel of the Surgical Services, will share in the enjoyment of improved facilities for efficient work.

Throughout the country emphasis in the teaching of surgery has shifted from the undergraduate to the graduate. The intern is no longer the forgotten man. Qualifying Boards have formulated what his training should be for every conceivable specialty.

For more than two years the Executive Committees of the Hospital have given careful thought to this problem and on January 1, 1940, a complete reorganization of the intern and resident system of the Surgical Services will go into effect. Before describing the new system, a brief review of the considerations that have guided the changes is in order.

Type of Training

In planning a curriculum for its interns and residents, an institution must first decide whether its resources are best suited to the training of the general practitioner, the specialist, or both. In arriving at this decision, the hospital must take stock of its personnel, laboratory equipment, university affiliations, facilities for original investigation and particularly its clinical material. As institutions differ in these resources, so they should differ in their educational programs—and it is highly desirable that these individual differences be maintained.

Large hospitals serving a civil governmental unit and smaller community hospitals have clinical resources that are unsurpassed for a rotating type of internship. The population of their wards presents a true cross section of the ills and ailments of a typical geographic area. Except under unusual circumstances, however, these institutions lack the elaborate facilities necessary for the proper training of specialists by subsequent residencies.

The Massachusetts General Hospital serves as a consultation center for a wide geographic area, exercising the power of selection over admissions, and tending to select for admission patients that present unusual diagnostic and therapeutic problems for which facilities are not available in their local communities. On the other hand, its rôle as a community hospital

should not be understated and is of real importance in maintaining a balanced teaching service.

Hospitals that select their admissions naturally tend to emphasize special interests, particularly favoring the development of newer phases of medical practice and clinical investigation. The embryo specialist requires above all a training in the critical evaluation of new, as well as established, diagnostic and therapeutic procedures. This may be given him freely if care is taken to provide a liberal substratum of routine cases. By established policy the Massachusetts General Hospital has for years nourished special interests and aptitudes. All special fields, obstetrics and contagious diseases excepted, are represented either formally, or through the proficiency of individual staff members. While the facilities are available for a limited rotating internship, the environment is superbly adapted to the education of the specialist.

Needs of Community

The needs of the community are to be considered in shaping a policy for graduate education. There is a popular emotional appeal to anything that is written or said regarding the importance of the general practitioner as contrasted with that of the specialist in the structure of American medicine. What the layman desires is a wise doctor ready and willing to give careful consideration to his personal problems and competent to solve most of them single-handed. When special experience or skill is required, he expects his doctor to aid him in the choice of the proper special consultant knowing full well that no one individual can possibly attain competence in more than a limited range of modern medical science. In this sense the term general practitioner is a misnomer—what is meant is better expressed by the older phrase, “family doctor.”

Family doctors are frequently found within the group of general practitioners but are by no means limited to this group. The diffuse and limited training of a “rotating” internship designed to equip a man

for the practice of general medicine often fails to develop the critical judgment and broad intellectual interest in medical science that is required in the best type of family doctor. The medical internship offered at this hospital has for many years produced a high type of family doctor and in addition it has been a stepping stone toward specialization in some circumscribed field of internal medicine. It is our opinion that a man so trained tends to be a wiser and more adequate family doctor than an individual who has diffused his energies in the acquirement of a superficial knowledge of the technics of several specialties.

The Hospital will continue to provide the community with family doctors by continuing the excellence of its training in internal medicine. It will also serve an equally vital need of American medicine by providing proper training for specialists and by the establishment of higher standards in this training. The Surgical Department plans to continue its present program of training specialists in general surgery. Specialized training will also be offered in the four surgical subspecialties that are accorded service status—orthopedics, urology, neurosurgery, and anesthesia.

Free Time

Whitehead points out that "qualities essential at a later stage of a career are apt to be stamped out in an earlier stage. This is only an instance of the more general fact, that necessary excellence can only be acquired by a training which is apt to damage those energies of mind which should direct the technical skill. This is the key fact in education, and the reason for most of its difficulties."

A frozen five year curriculum of hospital routine is unthinkable as it allows no latitude for the development of individual interests and proficiencies. A period of free time has been inserted in the curriculum to break the long period of clinical routine.

Basal Sciences and Research

The period of free time will enable men

to reestablish a contact with some field of basal science or if graduate work has already been done in basal science, to secure additional clinical experience either at the hospital or elsewhere.

Only a few men will wish to interpolate their program of clinical training with prolonged periods of research. A distinction is drawn between research work, in which a man is an active participant in an original problem under investigation, and work in the sciences affording a review of one or more subjects with emphasis on their clinical application. When individuals appear with a desire and talent for original investigation they may be specially nurtured and guided in their development. Others desiring to attain excellence as practitioners of surgery will not be required to do penance in an experimental laboratory in order to secure advanced clinical training.

One principle seems clear, that an individual be given free time to undertake special studies as an integral step in his educational program. These should be kept entirely flexible, and may be of a special clinical nature, a review of basal science or in occasional instances training in pure research.

Pyramiding

From the purely selfish viewpoint of a hospital, the most satisfactory structure for an intern and resident curriculum is a pyramid. Advance on the clinical ladder is then kept on a competitive basis with elimination of the less favored from year to year. In the end one individual is chosen as resident and is polished off by a year of intensive and full operating schedules.

The merit of this system is that it produces one well trained surgeon a year, and not infrequently there is a legend that this chosen man may carry on the torch in some other hospital as professor of surgery. The system also increases the gross tonnage output of laboratories of experimental surgery, as hopeful aspirants linger there some times for years, waiting for the clinical plum of "The Residency" to drop into their laps.

The sad result of this system, however, is that the country is full of able and earnest young men dropped in the mid-course of their specialized training and unable to secure posts in which they may complete their education. Approximately twenty-five applications a month are received for positions on the surgical resident staff. Many of these applicants have already invested two or three years in a surgical training. The net result is of course a continuation of the situation that responsible surgical organizations are laboring to bring to an end—the setting up of practice as specialists by inadequately trained men.

It is the duty of larger teaching hospitals to take stock of their resources and endeavor to turn out the maximum number of well trained surgeons that circumstances permit. As in any form of medical education it is not necessary to equip their steamer baskets with "assorted fruits and fancies, intellectual baggage sometimes known as impedimenta." As Alan Gregg recommends, "With the hook and line of curiosity, the rifle of straight reasoning and the matches and salt of critical judgment, many a traveller has learned to live off the country of experience."

Unusually promising men thought fit to undertake a long and unusually hazardous path may be further prepared in junior staff positions if there really proves to be a continued need for professors of surgery in the country.

For some time over seventy per cent of the surgical material of the Massachusetts General Hospital has been diverted to the technical training of the house staff. It is doubtful if this proportion can be significantly increased because of the heavy load of complicated cases that tax the skill of surgeons with years of experience. With no increase in bed capacity it was necessary to meet the problem by taking fewer men each year, but keeping these men longer. It is proposed to appoint six men a year and assure each man an opportunity to secure a five year period of training unless he desires to transfer to a subspecialty or proves grossly unsuited to a surgical career.

Duration of Training

The length of time required for post-graduate education in the specialties, particularly in surgery and related subjects that require practical experience in elaborate technics, is at first glance appalling, and requires justification.

This question has been answered by the American Board of Surgery in its decision that technical training under supervision in an institution must replace unsupervised technical experience obtained in private practice at the expense of an unsuspecting public. It has been answered also by the changed attitude of the medical student who now regards an intensive training under the guidance of the staff of a teaching hospital as preferable to the older system of serving as an apprentice in the private practice of an established specialist. The old custom of making a transition from a general practice to a specialty, with or without an additional brief period of graduate study, has fallen into disrepute.

Medical students have indicated their willingness to devote the time to this long period of institutional training. In the 1939 examination for interns at the Massachusetts General Hospital, the question was asked "How many years are you planning to devote to institutional training in surgery?" The answers are summarized in Table I.

Table I

Statistics from 41 applicants for surgical internship (1939) in answer to question "How many years are you planning to devote to institutional training in surgery?"

<i>Years</i>	<i>Number of men</i>
3 to 4	1
3 to 5	2
4	6
4 (more if research included)	1
4 to 5	4
4 to 6	1
5	14
5 to 6	7
5 to 7	1
5 (or more with time in research)	1
5 to 6 or even 7 if 1 or 1½ years spent in research	1
7 to 8	1
"any length"	1

Experience Preliminary to Specialization

Confusing statements may be found concerning the type and length of graduate education that should precede concentration on a specialty. These recommendations vary from a brief one year internship to ten years in general practice. One must be practical, however, in distinguishing between what is essential and what might be useful but is non-essential. Cushing has said "Since education is a lifelong process, we are all conscious of persistently shoring up to atone for educational deficiencies which could not possibly have been anticipated."

Important changes in the curriculum of the final years of the undergraduate course in first-rate medical schools have diminished the value of, and the necessity for, the one year rotating type of internship as a preliminary to specialized training. High-ranking students making the most of their opportunities have on graduation encompassed much of the theoretical instruction and at least some of the technical experience offered by this type of internship. Although only 3 per cent of the hospitals in the country offer the straight (i. e. specialized) internship as contrasted with the rotating or mixed service, it is to be noted that these institutions are the large medical centers with close university affiliations that tend to attract the most highly talented students. Rotating internships will continue to supply the largest number of general practitioners. A rotating internship is also an admirable step as a preliminary to a specialty like roentgenology or pathology but it is by no means a desirable step toward specialization in internal medicine or surgery. It may be classified as broadening and helpful, but not essential.

If the interest of a surgical service centers only on the technical procedures of the operating theater there is a real need for a preliminary internship on wards devoted to internal medicine. Fortunately, modern surgical services cultivate a thoughtful approach to the problems of the patient as an

individual and place emphasis on preoperative and postoperative treatment as well as pride in accurate diagnosis. Intimate and cordial relations are maintained with the sister services of internal medicine. Except in unusual circumstances it seems a wise economy of time for the embryo surgeon to enter directly on his special training on completion of medical school. The same line of reasoning applies equally well to a year spent in pathology as a preliminary to a surgical training. If additional experience in pathology is desired, it may be interpolated at a later date.

The following information regarding the new system for surgical interns and residents is abstracted from a small folder printed by the hospital. Copies of the more complete description may be obtained from the Director's Office.

Graduate Training in Surgery

The curriculum for interns and residents is designed to train specialists in surgery, including general surgery, orthopedic surgery, urology, neurosurgery, and anesthesia. The training in general surgery embraces gynecology, thoracic surgery, plastic surgery and other sub-specialties into which the clinical material of the Massachusetts General Hospital is not segregated at the present time.

General Surgery

At the Massachusetts General Hospital there are two general surgical services (East and West) each with 70 to 80 beds. This service division exists for the efficient administration of clinical responsibilities. There is an intimate and cordial merging of the two services in both the undergraduate and graduate teaching programs, as well as in house and visiting staff assignments. Joint rounds are conducted weekly so that unusual and instructive cases are available to the entire group.

Although the first year is termed the "intern" year it is designed to offer basic training to individuals who have definitely made up their minds to become specialists in surgery or one of its sub-specialties. Six appointments will be made annually. Two appointees start actual hospital service on each of the following dates: Jan. 1, May 1, and Sept. 1. If an appointee proves his aptitude for surgery by maintaining a high standard of work during the probationary period of internship, opportunity is offered to complete five years of training through the grade of First Assistant Resident. If the appointee shows a lack of aptitude for surgery, or for other reasons his

work proves unsatisfactory, his appointment will be terminated at the end of the intern year.

Intern Year (House Officer)

1A. *Anesthesia*—1 House Officer 2 months.

Emphasis is placed on the choice of the anesthetic agent and the physiologic disturbances attending anesthesia and operation rather than merely on the acquirement of anesthesia technics.

1B. *Surgical Infections*—1 House Officer 2 months.

A desk will be assigned in the Surgical Bacteriology Laboratory. Special bacteriologic and immunologic problems will be assigned from ward cases and on the Isolation Floor.

2A. *Transfusions*—1 House Officer 2 months.

2B. *Baker Memorial and Phillips House*—1 House Officer 2 months.

General surgical diagnosis and assisting at operations in the private divisions of the hospital.

3. *General Surgery*—2 House Officers 4 months.

Assignment will be made to a general surgical ward. Responsibility will be assumed for surgical diagnosis, clinical pathology, assisting at operation and pre and postoperative care.

Third Assistant Resident

1 year 4 months

1A. *Tumors* 1 Third Assistant Resident 2 months.

Assignment to tumor clinic where familiarity is gained with the fundamental principles underlying the radiation therapy of tumors. Supervision of patients on wards undergoing radiation therapy. Review of tumor pathology.

1B. *Urology* 1 third Assistant Resident 2 months.

2A. *Orthopedic Surgery* 1 Third Assistant Resident 2 months.

2B. *Neurosurgery* 1 Third Assistant Resident 2 months.

In rotation through the surgical sub-specialties emphasis is placed on the principles of diagnosis and technics that characterize the specialty rather than the acquirement of proficiency in specialized technics.

3. *General Surgery* (Admitting Floor) 2 Third Assistant Residents 4 months.

Responsibility is assigned for the admission and immediate care of emergency cases and also for the review of certain cases applying for admission by appointment. An insight into problems of hospital administration will be afforded by close association with the personnel of the Administrative Staff.

4. *General Surgery* 2 Third Assistant Residents 4 months.

Assignment is made to a general surgical ward.

Responsibility will be assumed for the care of surgical patients, including diagnosis, clinical pathology, operative technics and pre and post-operative care.

Second Assistant Resident

1 year

The six Second Assistant Residents will be required to cover during a calendar year five periods of service of four months each—three in orthopedic surgery including fractures and one each in urology and neurosurgery. Except for these requirements the year will be planned as a free elective period. This means that the typical schedule will require four months' clinical service in the hospital on one of the special services, leaving eight months available for study in basal science or some special clinical subject. From time to time an individual may devote an entire year to laboratory science or an entire year to clinical service.

The program of this year will be planned in advance and every effort be made to adapt it to the interests and desires of the individual. The hospital can give no assurance that appointments in other institutions or opportunities to work in the laboratories of Harvard University will be available, but efforts will be made to adjust the schedule so that advantage can be taken of such opportunities if they are awarded the individual.

Suggestions as to the opportunities available will be made and the projected course of study is subject to the approval of hospital authorities.

Illustrative opportunities may be listed as follows:

Laboratory Investigation in any laboratory in this country or abroad under a Fellowship or Scholarship of an outside agency.

Short Clinical Internship in any approved institution, either in a surgical specialty not represented at the Massachusetts General Hospital such as obstetrics, or in any other clinical field.

Basic Sciences. For individuals wishing a review of certain basic sciences but not contemplating a formal training in investigative methods, opportunity may be found available either at the hospital or at the Harvard Medical School for study in anatomy, biologic chemistry, surgical pathology, surgical bacteriology and immunology and so forth.

Special Clinical Subjects. Opportunities will be available at the hospital or elsewhere to work in special clinics or laboratories in subjects such as: peripheral vascular disease, thoracic surgery, gynecologic pathology, anesthesia, x-ray diagnosis, radiation therapy, and so forth.

Transfer to Specialty. Individuals planning to specialize in orthopedic surgery, urology, or neurosurgery may plan this elective year in consultation with the special service in which they wish to continue their special training. It may be de-

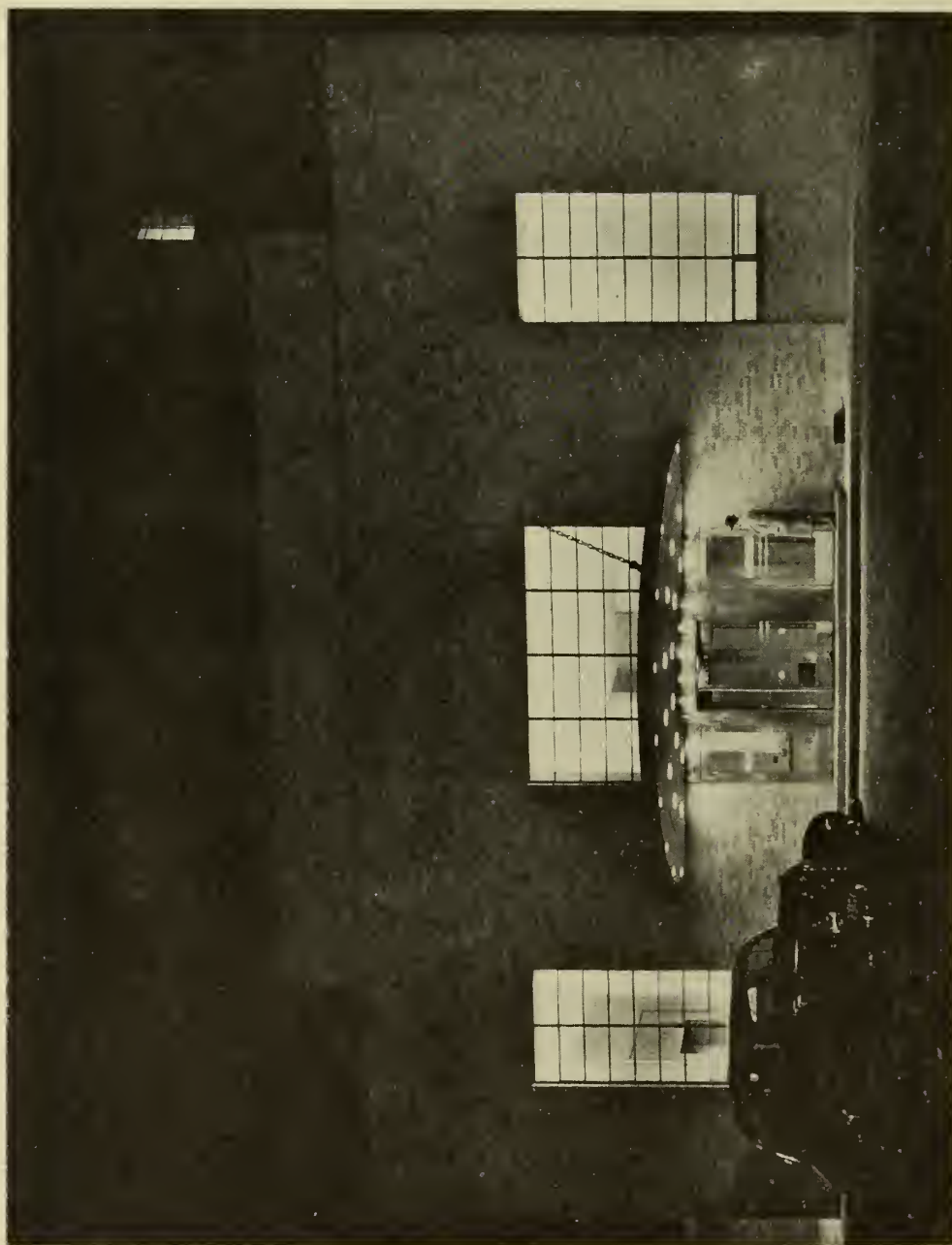


Photo by Judson B. Niece

ENTRANCE TO THE GEORGE ROBERT WHITE BUILDING

voted to clinical work on that service or devoted to laboratory investigation or basal science particularly pertinent to the special field. Arrangements to transfer from general surgery to a specialty must be planned a year in advance and are dependent on an existing vacancy in the specialty and the securing of a satisfactory substitute in general surgery by the hospital.

From time to time individuals desiring to enter a sub-specialty of surgery not formally represented at the Massachusetts General Hospital may terminate their appointment during this year to continue their surgical training elsewhere. The only condition to such withdrawal is that the hospital is able to secure a satisfactory substitute for the later period of the course and that the change be planned at least a year in advance.

First Assistant Resident

1 year 4 months

In this period responsibilities will be increased particularly in regard to technical experience in operative surgery under supervision.

1. *Baker Memorial and Phillips House* 2 First Assistant Residents 4 months.

A service in the private divisions at this time will be particularly valuable following the interruption of clinical training for work in investigation or in the basal sciences during the preceding year. General surgical diagnosis and assisting at operations.

2. *Out-Patient Surgical Clinics* 2 First Assistant Residents 4 months.

The surgical clinics of the Out-Patient Department are conducted both mornings and afternoons. The responsibility of the clinic will center on the assistant resident in charge, with the visiting staff acting in consultation capacity. Close correlation with the clinical work of the wards will be established by morning visits on the wards and afternoon follow-up clinics conducted jointly with the house staff from the wards.

3. *General Surgery* 2 First Assistant Residents 4 months.

4. *General Surgery* 2 First Assistant Residents 4 months

Resident Surgeon

1 year

From the six men completing the course of training as first assistant resident or from outside applicants, two individuals will be appointed annually to the posts of resident surgeons.

Appointees to these posts will act as executive heads of the surgical services under the direction of the visiting staff. Assistant residents of all grades and surgical interns will be under their direction except when assigned to special services at which time they will be responsible to the resident surgeon of the special service. Resident surgeons will take an active part in the teaching of

undergraduates and have access to the surgical laboratories for pursuit of research problems.

Surgical Specialties

(Orthopedic Surgery, Urology, Neurosurgery, and Anesthesia)

As a matter of general policy not only the educational curriculum of the specialties but the administrative and clinical activities of the special services are closely knit with general surgery. The house staff in the specialties will be chosen from applicants who have had preliminary training in other institutions as well as from candidates completing the first two years of the general surgery curriculum. (See note under General Surgery, Second Assistant Resident.)

Orthopedic Surgery

The Orthopedic Service occupies a separate floor of 50 beds. Fractures, certain cases of osteomyelitis and bone tumor as well as pure orthopedic cases are cared for on this floor. The Orthopedic Clinic of the Out-Patient Department cares for an average of 51 patients per day. Approximately 350 patients a year receive treatment for orthopedic conditions in the private wards.

Third assistant residents in general surgery are assigned to this service for two months. Three of the six second assistant residents are assigned to this service for an additional period of four months.

The Orthopedic Service in co-operation with the Orthopedic Service of the Children's Hospital offers a formal training for specialists in this field.

The curriculum for training as a specialist in orthopedic surgery is as follows:

1. Preliminary appointment in general surgery of 2 years or its equivalent.

2. Combined service at the Massachusetts General Hospital and the Children's Hospital of Boston divided as follows:

8 months—Children's Hospital.

8 months—Massachusetts General Hospital.

8 months—Basal Sciences, pathology and anatomy.

(At the present time opportunity for study in basal science cannot be guaranteed to every man by the hospital. Efforts are being directed toward increasing the opportunities in this field.)

3. Certain men may secure additional training in the position of resident.

Urology

The Urologic Service occupies a separate floor containing 27 beds and conducts Out-Patient clinics in urology and venereal disease caring for an average of 54 patients a day. Approximately 500 patients a year receive treatment for urologic conditions in the private wards.

Third assistant residents in general surgery are

assigned to this service for two months. One of the six second assistant residents is assigned to this service for an additional period of four months.

The Urologic Service offers a formal training for specialists in this field with the following curriculum:

1. Preliminary appointment in general surgery of 2 years or its equivalent.
2. One year second assistant resident of which 4 months may be devoted to special study in basal science.
3. One year first assistant resident.
4. One year resident.

Neurosurgery

The Neurosurgical Service is closely merged with the Medical Service of Neurology and they jointly occupy a separate floor of 25 beds. A combined Out-Patient Clinic cares for an average of 45 patients per day. Both services are closely linked with the Medical Service of Neuropsychiatry which has a separate ward of 18 beds and is in turn affiliated with the McLean Hospital, the psychiatric division of the Massachusetts General Hospital, an institution with 235 beds. Joint conferences are conducted by the three services.

Approximately 250 patients a year are treated for neurosurgical conditions in the private wards. Over 400 major operations a year are performed on the combined public and private services.

Third assistant residents in general surgery are assigned to this service for two months. One of the six second assistant residents is assigned to the Neurosurgical Service for an additional period of four months.

The Neurosurgical Service offers a formal training for specialists in this field with the following curriculum:

A preliminary training of two years in general surgery or its equivalent is advisable before undertaking the specialized training in neurosurgery. It is essential that experience in neurology, neuropathology and neurophysiology be included in the educational program. To preserve flexibility in the long training period, the house staff positions affording clinical and operative experience are administered with due regard to the needs of the individual. Periods for review of basal science or investigative work may be alternated with periods of clinical responsibility. Periods of study in other neurosurgical clinics are encouraged, and opportunities provided for individuals from other institutions who wish to take only a portion of their training at this clinic.

Three clinical posts are available in neuro-

surgery in addition to those reserved for members of the general surgical house staff:

Second Assistant Resident: 8 months (The remaining 4 months of the year are reserved for a Second Assistant Resident from the general surgical services.)

First Assistant Resident: 1 year.

Resident: 1 year. Under special circumstances a second year may be available in the residency or by special appointment to the junior staff.

Anesthesia

The Anesthesia Service assumes the responsibility for the administration of anesthesia to cases in the Massachusetts General Hospital including the Baker Memorial Division, and the Out-Patient Department. In 1937, 15,576 operations were carried out in these divisions of the hospital.

House officers in general surgery are assigned to Anesthesia for two months as a first step in their training. Emphasis is placed on the observation of the physiologic behaviour of patients subjected to anesthesia and surgery.

In addition, the Anesthesia Service offers a curriculum for the formal training of anesthesiologists. As preliminary training a general internship of at least one year is required.

Two assistant residents in anesthesia are appointed annually. In this period increasing responsibility is given in the technics of anesthesia.

One resident in anesthesia is appointed annually.

On special appointment a third year may be offered as resident or assistant anesthesiologist, offering increased responsibility in anesthesia and opportunities for teaching and research. A close association with the Departments of Pharmacology and Physiology at the Harvard Medical School is encouraged in order to emphasize the relationship of these sciences as applied to clinical anesthesia.

Maintenance and Stipends

Interns, Assistant Residents and Residents receive room, board and laundry while on clinical service in the hospital.

Second Assistant Residents will receive maintenance during the periods of actual clinical service at the hospital but not during periods of elective study in basal science, laboratory investigation or work in other institutions.

Salaries are paid to the Residents, First and Second Assistant Residents. They are determined in each case by vote of the Board of Trustees and vary in amount depending on the length of service in the hospital. No salary is paid during the intern year or to third assistant residents.

Algernon Coolidge

Memorial on the death of Algernon Coolidge spread on the Records of the Faculty of Medicine, November 3, 1939.

Algernon Coolidge, Professor of Laryngology, *Emeritus*, died in Boston on August 16, 1939, in the eightieth year of his age. Graduating from Harvard College in 1881, he entered the Medical School and received the degree of Doctor of Medicine in 1886. Positions on the teaching staff and Faculty of Medicine were held as follows: Clinical Instructor in Laryngology, 1893-1906; Assistant Professor of Laryngology, 1906-1911; Professor of Laryngology, 1911-1925; and Professor of Laryngology, *Emeritus*, 1925-1939. In 1918 he served as Acting Dean of the Graduate School of Medicine.

Dr. Coolidge served as a member of the staff of the Massachusetts General Hospital for approximately forty years, rising to be head of the service for nose and throat diseases. Since 1921 he had been a Trustee of the Hospital.

As an officer of both institutions, the energies of Dr. Coolidge were continually devoted toward preserving and strengthening the bonds between the Harvard Medical School and the Massachusetts General Hospital. Particularly as Trustee of the Hospital, he was in a position to interpret the needs of the Medical School to the fellow members of the Board in the formula-

tion of constructive programs for the improvement of teaching and the care of the patient. In this way he was able to further the development of full-time units at the Hospital both in Medicine and Surgery. Important organization changes in Neuropsychiatry and the introduction of teaching and investigative work at the McLean Hospital were largely the product of his untiring efforts.

His intimate personal friendship with President Lowell strengthened the bonds between University Administration and the Medical School for many years. He was attracted by the problems of the Examinations Committee and was in part responsible for the introduction of General Examinations in the Medical School.

In his professional specialty Dr. Coolidge was a leading figure in the nation, serving as President of the American Laryngological Association. He was the first in this country to use a bronchoscope for the extraction of a foreign body from the air passages.

Dr. Coolidge was born in Boston, January 24, 1860, the son of Algernon Coolidge, M.D. 1853, and Mary L. Coolidge. In 1896 he married Amy P. Lothrop of Boston, who survives him.

Respectfully submitted,

EDWARD D. CHURCHILL,
LINCOLN DAVIS.

The Alumni Association of the Harvard School of Public Health

Edward G. Huber, M.D., Dr.Ph., Assistant Dean, School of Public Health

Under the stimulus of those provisions of the Social Security Act which make Grants-in-Aid to the various states to strengthen state and local health departments and to train personnel for health department work there has been a notable increase of interest in the public health. The Social Security Act is the first national legislation to protect and promote the national health and is considered to be the first step in a national health program. In this way federal funds suddenly made possible so many new public health activities for which there was no trained personnel available, that the first tendency was to train as many workers as possible in the shortest possible time,—six weeks to three months. This was soon found to be a serious mistake. There has, therefore, been a steadily increasing number of students in each successive year at the Harvard School of Public Health where training has always been given on the basis of a full academic year. Since the School and its alumni are occupying a prominent place in the public health field, a few historical items are worth noting.

In 1909 the first Department of Preventive Medicine and Hygiene in a medical school was established in the Harvard Medical School. Work in public health was offered to graduates in medicine as well as to undergraduates, and in 1911 the degree of Doctor of Public Health was first conferred. In that year, the Harvard Graduate School of Engineering inaugurated its Department of Sanitary Engineering. Two years later a "Harvard - Technology" School of Public Health, under the joint management of Harvard University and the Massachusetts Institute of Technology was organized. The Harvard University

participants in this pioneer school were the Department of Preventive Medicine and Hygiene of the Medical School, and the Department of Sanitary Engineering.

During the next few years, as the field of public health broadened, there gradually developed in the various other faculties of Harvard University a number of activities which had some bearing on public health. All these furnished the nucleus for a new school of public health of larger scope which was organized in Harvard University and gave its first instruction during the academic year 1922-1923. The Department of Sanitary Engineering and the School of Public Health maintained the close relationship which had begun a decade before.

Until 1937 there was no alumni organization. This was not due to any lack of interest on the part of the graduates, but to the fact that the students came from all parts of the United States and from many foreign countries. There was thus very little reason for a formal association, as the chance that more than a few would ever be together at any given time was slight. But two important trends became manifest. In the first few years of the School a large proportion of the students came from foreign countries. The trend toward a very much larger proportion of registrants from the United States was noticeable, even before the Social Security Act (through its provisions for personnel training) not only increased the total number of students in the School of Public Health and the Department of Sanitary Engineering, but also still further increased the proportion of American students. The second trend is toward a younger group of students than those of the previous decade.

As the number of alumni (and alumnae since 1936) increased, it was noted that more and more of them were to be seen at the annual meetings of the American Public Health Association. The informal gatherings of alumni at these meetings indicated that a permanent organization would be well received.

The Class of 1937 took the initiative, and at its final meeting before leaving for their homes, voted to form an association to be known as the Alumni Association of the Harvard School of Public Health and the Department of Sanitary Engineering of the Graduate School of Engineering. This organization, for the present at least, they decided should be informal, and its chief purpose should be the maintenance of a closer relationship between alumni and the University, especially in the field of public health. Dr. Lloyd J. Florio and Mr. Harvey G. Rogers of the Class of 1937 of the School of Public Health and the Department of Sanitary Engineering, respectively, were elected as alumni representatives until a permanent organization could be formed at the October 1937 annual meeting of the American Public Health Association in New York City.

Accordingly, between seventy-five and one hundred alumni and members of the Faculty met on October 8 in New York City. Dean Drinker presided. Short talks were given by Dr. Wilson G. Smillie and Professor Gordon M. Fair. Professor Fair and Dean Drinker spoke chiefly of recent developments in the Department of Sanitary Engineering and the Harvard School of Public Health respectively.

The following officers were elected:

President: Dr. Henry D. Chadwick

Secretary: Professor Gordon M. Fair

The 1938 and 1939 meetings were held at Kansas City and Pittsburgh, respectively; the latter at the Harvard-Yale-Princeton Club through the courtesy of Mr. Charles E. Robinson, Secretary of the Harvard Club of Western Pennsylvania. The 1938 President was Dr. Lloyd J. Florio, Marshall, Michigan. He was succeeded by Professor Herman G. Baity,

University of North Carolina. Dr. Alton S. Pope, of the Massachusetts Department of Public Health, is Vice-President and Dr. Edward G. Huber, of the Harvard School of Public Health, is Secretary.

The Alumni Association, which is made up of men and women who are in public health work, should be of great benefit both to the University and to the alumni. Not the least of the advantages to the alumni is the fact that the School receives very frequent requests for recommendations for positions and is thus in a position to aid its graduates in advancement. Every effort will be made to keep members of the Association informed of the work and publications of the teaching staff. In turn, the University will have the advantage of having an interested, organized body of alumni, with three hundred members.

APPOINTMENT

Dr. LeRoy A. Schall, who has been instructor in laryngology at the Harvard Medical School since 1926, has been appointed Walter Augustus Lecompte Professor of Otology and Professor of Laryngology. He succeeds Harris P. Mosher, '96, who has taught at the Medical School for more than thirty years and now becomes professor *emeritus*.

Dr. Schall received his medical degree from Jefferson Medical College in 1917. He is also on the staffs of the Massachusetts Eye and Ear Infirmary and the Palmer Memorial Hospital, Boston.

CUTTER LECTURES

The annual Cutter Lectures on Preventive Medicine were given this year by Dr. Ludvig Hektoen, executive director of the National Advisory Council of the U. S. Public Health Service, and Dr. James B. Murphy, member, in charge of cancer research, of the Rockefeller Institute for Medical Research. Dr. Hektoen's lecture, entitled "Cancer Control with Special Reference to Public Health Aspects," was given January 15, and Dr. Murphy talked on January 22, on "The Development of the Present Trends in Cancer Research."

ASSOCIATION OFFICERS

Lincoln Davis, *President*
 Lawrence K. Lunt, *Vice-president*
 Clark W. Heath, *Secretary*
 Marshall K. Bartlett, *Treasurer*

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EDITOR

Clark W. Heath

BUSINESS MANAGER

Marshall K. Bartlett

Mrs. K. B. Wilson, Secretary
Room 108, Harvard Medical School
Boston, Mass.

EDITORIAL

The editor is glad to give the space to the following letter by Dr. Reginald Fitz who takes the Officers and Council to task for not realizing to the full the potentialities of the Harvard Medical Alumni Association. The matter does not take them by surprise. Something of the sort, but perhaps not so well formulated as in Dr. Fitz's letter, has been growing in the minds of the Officers and Council for some time. Dr. Fitz had already burst his bombs in less disguised manner at a dinner of the Council on December 12. Dr. J. Dellinger Barney collected together representatives of different classes at a dinner on December 14. It was obvious at this dinner that there is great class and alumni enthusiasm and an earnest desire to assist the School on the part of its graduates. Plans have already been made to call a meeting on June 12 in New York City during the Annual Session of the American Medical Association. It is expected that over 300 alumni should be present, and it is hoped that they will find the entertainment suitable to the occasion.

From a number of meetings, dinners, and above all, from just plain talk the editor has collected together a surprising amount

of information about classes, class officers, class reunions and just what the Alumni Association can and will do about these and other matters. So much so, that the editor is forced to claim that it is the Alumni Association, not the alumni, which is forgotten. For instance, do the alumni know that each class which graduated from the Harvard Medical School since 1914, has a living secretary, name and address recorded in our files? Please see the list in this issue for the secretary of your class. Do they know that this means that each class since 1914 can organize its resources, plan a very worthwhile series of reunions, and finally at its 25th reunion present to the Medical School a very useful, if not princely sum of money? Do they know that the Association is prepared to circularize classes, to give information of value regarding reunions of other classes and methods of raising money by classes? Do they know that the Medical School has many pressing needs for unrestricted funds? Do they know that the Association has alphabetical, class and geographical files of graduates? Do they know that the Association has an office in Building A of the Medical School which each alumnus is invited to use should he come to Boston? Do they know that the Association would like to enlarge these facilities, to give the secretary a full time status in place of the present half time status, to enlarge the BULLETIN, and to take a more active part in bringing information of the School to the alumni and of the alumni to the School? Do they know, finally, that the Association is somewhat handicapped in these worthwhile plans because only 15 per cent. of the 5,000 odd alumni contributed only \$2,107 last year in response to the annual appeals?

The affairs of the Association are at present in very good shape. The BULLETIN is just beginning to receive enough advertising to pay for itself. On the other hand the Association should become a more useful agent to the local and distant alumni. It is the wish of the Officers and Council that the alumni submit suggestions for in-

creasing our scope and usefulness. Such comments or suggestions should be in the secretary's hands by February 15, in order to be presented at the next meeting of the Council.

ALUMNI IGNOTI

To the Editor of the
Harvard Medical Alumni Bulletin.
Dear Sir:

In the years during which I have been entitled to membership in the Harvard Medical Alumni Association I have never been wholly satisfied with the organization. As I have followed the career of the School I have watched it emerge from a small Massachusetts medical college into one of the great medical schools of the country, of national importance, and with alumni usefully occupied in nearly every state of the Union. As I have observed the career of the Medical Alumni Association I have failed to note the same degree of progressiveness.

The Harvard Medical Alumni Association has been kept alive largely by the unselfish loyalty of a comparatively small proportion of the Medical School graduates, on the whole living near Boston, and continually doing all in their power to serve the School as alumni should. These alumni deserve all manner of praise. They have published the Harvard Medical Alumni Bulletin; they have served in an important way to bring about the construction of Vanderbilt Hall, an appendage to the School of incalculable value; they have raised funds with which to help needy students, to look after students who fall ill, to add to the importance of the collection of books in the Library, and even toward the development of a Medical School Alumni Fund which before many more years have passed will reach the not inconsiderable sum of a hundred thousand dollars. All this is on the good side of the ledger.

Where I think the Alumni Association has fallen down has been in its narrowness. Too small a proportion of the alumni body has had opportunity to play a part in the activities of the Association and too few of the alumni have had their appetites for

Harvard knowledge appeased with sufficiently personal morsels of news about the School and what was going on in it.

There are 4800 living graduates of the Harvard Medical School. Of these, half live outside of New England and two-thirds live outside of Massachusetts. I think it a pity that Harvard medical alumni living at a distance from the School are not given a better chance to have their Harvard spirit cultivated.

What I would like to see happen is this: I hope for a more active and more representative Harvard Medical Alumni Association than now exists. Such an association should meet twice each year; once in whatever place the American Medical Association chooses to meet, and once at the Harvard Medical School. At the meeting which would take place at the time of the American Medical Association convention, there would be a dinner, carefully arranged beforehand, well announced, and at which various distinguished speakers selected by the President of the Association would talk. Business would be reduced to a minimum. The object of this meeting would be to gather together Harvard Medical alumni from all parts of the country and to give to those who wish it a chance to hear something of the School from whatever viewpoint the President chose to have the subject approached.

The meeting at the School would take place regularly on the morning before Commencement Day. First, there would be a short annual business meeting. The election of officers would be announced, reports would be submitted, and policies of the Association would be discussed. Then there would follow a discriminating program arranged by the Medical School, a program designed to illustrate newest developments in the School, and to demonstrate to the alumni whatever seemed of greatest interest in new teaching methods, in the advancement of scientific knowledge, or in the clinical field.

The day before Commencement seems the most logical day in the year for an alumni meeting of this character to assem-

ble. Commencement Day is more likely than any other day to attract to Harvard the greatest number of alumni who live at a far distance, and these men are especially the ones who should be encouraged to revisit the School. Perhaps an *al fresco* lunch could be arranged to conclude the meeting and later those who wished then could go to Class Day or to see what Harvard might do to Yale at baseball.

A Medical Alumni Association of this character should have a form of organization somewhere between that of the Associated Harvard Clubs and that of the general Alumni Association. There should be a strong group of officers: a President, three Vice-Presidents, a Secretary, a Treasurer, and a certain number of directors. The President and the first and second Vice-Presidents should be elected by ballot annually; the Secretary and the Treasurer should have longer terms of service in order to maintain a continuation of policy. A proportion of the directors should be elected by ballot, each to serve for a set term of years; others should be appointed in several ways, by the officers, a faculty member, by the Dean of the Medical School, one by the class about to graduate, and perhaps one each by the New York and California alumni. Practically all of the business of the Association could be carried on by correspondence. The third Vice-President, who should be an appointed officer, the Secretary, the Treasurer, and some of the directors, however, should live near Boston to act as an Executive Committee and to keep the machinery in motion. The majority of officers and directors should be elected from a group of representative candidates selected to run for office because of their distinctiveness and representativeness as Harvard Medical alumni. They should not be elected because they live conveniently close to the School.

An association of this general character might be worth developing for several reasons. In the first place, because many very distinguished alumni scattered over the country are sincerely interested in the welfare of the School and wish to keep abreast

of its progress. They find it so difficult to return to the School that means should be found to bring the School to them. In the second place, because a closely-knit, effective association of alumni can be helpful to its parent school in a variety of ways once the association has clearly in mind what are the various perplexities with which the parent school at any time must contend. At present too few Harvard Medical alumni know about the School and its problems. In the third place, because an active, sympathetic interest on the part of alumni is a healthy stimulant to any school, stimulating alike to student body and faculty. Our School has a number of interested alumni but they are not well enough bound together to be as influential and stimulating as they might be.

On the whole, I believe that our present Medical Alumni Association could be improved without undue effort. I think it needs something like a dose of testosterone to make it livelier and more interesting to many more potentially active members than it now affects. If it seems desirable to other alumni that the Association be so treated, they must say so. I suggest to anyone agreeing with those views that he send a postcard to the Secretary of the Harvard Medical Alumni Association, Shattuck Street, Boston. Let him write on the back of it that he would like to see the Association rejuvenated. If enough *alumni ignoti** express themselves to this effect, interesting changes in the Constitution and By-Laws and in the activities of the Medical Alumni Association are not unlikely to take place.

Yours sincerely,

REGINALD FITZ, '09

To the Editor of the
Harvard Medical Alumni Bulletin.
Dear Sir:

Your readers may be interested to hear about a dinner, arranged by the writer, which was held at the Boston Harvard Club on December 14, 1939. This meet-

*"Forgotten alumni", Ed.

ing was called for the purpose of discussing and putting on an organized basis a plan for each class at the Medical School to raise and present to the School a sum of money on the occasion of its twenty-fifth anniversary.

Those present included Doctors Lincoln Davis and Clark W. Heath, President and Secretary respectively of the Medical Alumni Association, C. Sidney Burwell, Dean of the School and Reginald Fitz, Assistant to the Dean. Representing the 10th, 15th, 20th, and 25th year classes, both of last year and this year, as President or Secretary, there were also present Doctors Arlie V. Bock, Tracy Putnam (who came on especially from New York), Joseph Garland, William N. Wishard, Jr. (who made the long trip from Indianapolis particularly for this event), Dwight Siscoe, James M. Faulkner, A. O. Ludwig, Sylvester B. Kelley, and the writer.

It was unanimously agreed (1) that the idea of raising money for the School was desirable, (2) that a very respectable sum could be collected especially if an early start were made, (3) that ways and means of raising the money could best be settled by the individual classes. To this end it was felt that an early and permanent organization of class officers was of importance. It was especially emphasized that any efforts on the part of classes to raise money should be entirely voluntary. It was felt by all of us that whatever money may be collected should be given to the School for such use of the interest as may be decided upon by the Administrative Board. Finally it was agreed that the Medical Alumni Association might, by certain changes and improvements in its organization, be of very great help in bringing about the desired results.

Dr. Davis, in his capacity as President of the Alumni Association, expressed official and enthusiastic approval of the plans which were discussed.

J. DELLINGER BARNEY, '04.

To the Editor of the
Harvard Medical Alumni Bulletin.

I am delighted to know that the Medical School is making every attempt to bring the Alumni in as close contact with the school as possible. I have taken pleasure in contributing the little bit that I have to the Association through these many years. We can justly be proud of the Harvard Medical School. It is only by the support of the whole Alumni body that we can give as much to the school as it deserves and get in return what the school is giving us now. The morale of the Alumni body is getting better and better each year and is a source of gratification to me as an alumnus more than a quarter of a century out of school.

JOHN A. WENTWORTH, '13.

REUNIONS

Class of 1915

Eleven members of the class of 1915 gathered at a dinner on January 18, to make plans for the 25th reunion of the class. Present were: A. V. Bock, S. Cline, J. G. Downing, J. S. Hodgson, A. M. Jackson, J. C. Janney, S. R. Meaker, F. Packard, J. H. Shortell, H. C. Sowles and G. W. Van Gorder. Fabyan Packard was appointed chairman of arrangements. Tentative plans were made to have a two-day reunion on the week-end of June 8 or June 15. Members of the class will receive ballots and further information as plans progress.

Class of 1920

Arrangements are being made for a 20th reunion on June 7 and 8. Clarence J. Gamble has been appointed chairman of arrangements. Members of the class will receive further information shortly.

Class of 1930

Plans to have a 10th reunion and dinner are under way. This is to be held in Boston in June. Keep it in mind and begin making plans to be there. Further plans will be made here and also by direct communication from Harry Spence and Alfred Ludwig.

LIST OF PERMANENT CLASS SECRETARIES

- '00—Walter B. Cannon, 25 Shattuck St., Boston.
- '01—Horace Binney, 370 Commonwealth Ave., Boston.
- '02—George W. Winchester, 128 Blue Hills Pkwy., Milton, Mass.
- '03—John Homans, 721 Huntington Ave., Boston.
- '04—J. Dellinger Barney, 87 Marlborough St., Boston.
- '05—Gerald Blake, 212 Beacon St., Boston.
- '06—J. Herbert Young, 66 Commonwealth Ave., Boston.
- '07—James B. Ayer, 319 Longwood Ave., Boston.
- '08—George G. Smith, 1101 Beacon St., Brookline.
- '09—James J. Hepburn, 65 Bay State Road, Boston.
- '10—Alexander M. Burgess, 454 Angell St., Providence, R. I.
- '11—James H. Means, 15 Chestnut St., Boston.
- '12—George R. Minot, Boston City Hospital, Boston.
- '13—Elliott C. Cutler, Peter Bent Brigham Hospital, Boston.
- '14—W. Richard Ohler, 319 Longwood Ave., Boston.
- '15—George F. Dwinell, 814 Elm St., Manchester, N. H.
- '16—Donald Munroe, Boston City Hospital, Boston.
- '17—John Brady, P. O. Box 537, Oswego, Oregon.
- '18—Robert W. Lord, 122 Waterman St., Providence, R. I.
- '19—Joseph Garland, 264 Beacon St., Boston.
- '20—Tracy J. Putnam, Cornell Medical Centre, N. Y.
- '21—Harold R. Merworth, 30 Eighth Ave., Brooklyn, N. Y.
- '22—George C. Caner, 63 Marlborough St., Boston.
- '23—Arthur M. Walker, Gwynedd Valley, Pa.
- '24—James M. Faulkner, 262 Beacon St., Boston.
- '25—William W. Wishard, Jr., 2050 N. Delaware St., Indianapolis, Ind.
- '26—Henry E. Gallup, West St., Dedham, Mass.
- '27—Charles J. Kickham, 32 Halifax St., Jamaica Plain, Mass.
- '28—Ernest D. Liston, Fitz Simmons Gen. Hosp., Denver, Colo.
- '29—Paul G. Sanderson, 32 Westford Ave., Springfield, Mass.
- '30—Henry M. Spence, 4105 Live Oak Ave., Dallas, Texas.
- '31—John A. Abbott, 384 Commonwealth Ave., Boston.

- '32—Claud E. Welch, 264 Beacon St., Boston.
- '33—Fred A. Simmons, 101 Bay State Road, Boston.
- '34—John R. Graham, 311 Beacon St., Boston.
- '35—David H. Clement, 300 Longwood Ave., Boston.
- '36—Barnard D. Todd, 1 Monument Sq., Beverly, Mass.
- '37—Joseph R. Frothingham, 157 Bay State Road, Boston.
- '38—Robert S. Hurlburt, 4 Gerry Landing Rd., Cambridge.
- '39—Alexander Bill, Jr., Babies Hospital, New York City, N. Y.

Note: According to our records the men on this list are the permanent secretaries of their classes. We would appreciate having any corrections or additions.

HARVARD SCIENTISTS HONORED

Two Harvard scientists were honored in Memphis, Tenn., at meetings of two organizations bearing almost identical titles. On November 21, at the meeting of the American Society of Tropical Medicine, the Walter Reed Medal was bestowed on William B. Castle, '21, Professor of Medicine at Harvard, and the speech of presentation was made by Richard P. Strong, Professor of Tropical Medicine, *Emeritus*. Two days later, at the meeting of the American Academy of Tropical Medicine, the Theobald Smith Medal of Washington University was awarded to Dr. Strong, and Dr. Castle made the speech of presentation.

The latter medal is named for the late Dr. Theobald Smith, who was George Fabian Professor of Comparative Pathology at Harvard from 1896 to 1915. The Reed Medal is a memorial to the late Dr. Walter Reed, surgeon in the U. S. Army, whose research and experiments in yellow fever were of the first importance. Until last week's meeting, the medal had not been awarded in four years.

The closing paragraphs of Dr. Strong's remarks when he presented the Reed Medal to Dr. Castle are here given:

"Dr. Castle; on this occasion it seems particularly appropriate to recall that over a hundred years ago (1822) William Beaumont carried out successfully on St. Martin, his patient with a gastric fistula, a long and laborious research during ten years upon

the gastric juice and the physiology of digestion.

"You, Dr. Castle, endowed, as Beaumont, with exceptional intellectual ability and recognizing the possibilities before you, but in addition equipped with a modern scientific education and more efficient laboratory weapons, have blazed new and clearer trails of understanding in regard to a number of these problems. So I greatly appreciate the honor assigned to me today to present to you on behalf of the American Society of Tropical Medicine this Walter Reed Medal, with the image of Walter Reed engraven on it, and we ask you to accept it as a token of our recognition of your meritorious achievements in tropical medicine and of the leadership you have demonstrated in these careful and detailed scientific investigations which have resulted in such important additions to our knowledge of sprue and the other anemias, and their successful treatment."

THOMAS J. BURRAGE

Thomas J. Burrage, '03, of Portland, the ranking Medical Reserve officer in Maine, has reached the mandatory retirement age of 64.

Thus closed an Army career which started in 1917 when he was commissioned major. He was called to active service March 1, 1918, as assistant chief of staff of medical service, Base Hospital, Camp Jackson, Columbia, S. C. For more than six months after landing in France in August, 1918, he was chief of medical service at Base Hospital 54, becoming commanding officer of the base March 25, 1919. He was appointed lieutenant colonel Oct. 16, 1918, and colonel in 1924. Before his discharge from the Army May 9, 1919, he was cited by General Pershing for "exceptionally meritorious and conspicuous service." In 1932 he became the first Portland civilian to receive the Purple Heart decoration.

Burrage has served as chef de gare, commanding officer, of Voiture Locale, 40 and 8, as chairman of Portland Chapter, American Red Cross, and as commander of Harold T. Andrews Post, American Legion. As an ROA member he has been one of the most active officers in the State.

DONALD WALLACE PORTER

Donald Wallace Porter, '12, died on September 8, 1939, from a coronary occlusion. He had been in the practice of pediatrics in New Haven from 1915 until June, 1937, when he was forced to withdraw as a result of a coronary episode. He was one of the leaders in medicine in his city, and had shown that it is possible to follow the best traditions of the family doctor even though one's practice is restricted to a single field. He was looked to by the families of his patients not alone for the care of a current illness but for advice on the upbringing of their children which ranged far beyond the ordinary bounds of medicine.

Civic and church boards and committees prized him as a member, and he gave much time to such public-spirited activity, even after failing health forced him to stop practice. The quality of the man is best shown by the spirit in which he took the decision to give up medicine, and the use he made of the time remaining to him thereafter. He insisted on doing what his strength permitted for the good of mankind, and refused to withdraw from the world so long as he could remain in it. He was a useful and cheerful citizen to the very end.

NOTICE

A biography of the late Harvey Cushing, '95, is being prepared, at the request of Mrs. Cushing, by John F. Fulton, '27, Sterling Professor of Physiology at Yale University. Dr. Fulton will be grateful for letters, anecdotes, and other memorabilia of Dr. Cushing. Dr. Fulton's address is 333 Cedar St., New Haven, Conn.

BOOK REVIEWS

OTOLARYNGOLOGY IN GENERAL PRACTICE, Lyman G. Richards, M.D. '19, 352 pp., illustrated. The MacMillan Company, New York, 1939. Price \$6.

In writing this book Dr. Richards has made an important contribution to the diagnosis and treatment of disease of the upper respiratory tract. It is written for the general practitioner of medicine as the title implies, but it is filled with information by which the sophisticated "internist" and the "specialist" may profit even more. As such, its sane, wise, practical point of view, its simplicity of expression and its clarity in analysis have brought out the general as well as the specific problems of upper respiratory disease.

The book is written, as Dr. Richards notes, to assist the "general practitioner in differentiating (1) between those conditions in which he can reasonably be expected to take personal charge of treatment, and (2) those which unquestionably fall within the domain of the specialist, no matter how inaccessible." But it is far more than that.

The arrangement of the contents is essentially that of the presenting clinical complaints of the patient with more technical chapters on operative procedures. Careful consideration of detail with thoughtful evaluation of useless as well as important methods of treatment are outlined. Sulfanilimide receives its proper consideration but the dangers of its use are perhaps underemphasized. Nose drops are discussed for a variety of ailments but no mention is made of the danger of lipoid pneumonias caused by oily drops instilled into the nose and pharynx of debilitated children and sleeping adults.

General consideration and prevention of the common cold are carefully and well discussed. It is perhaps too much to expect that an otolaryngologist would recommend complete abstinence of nasal instrumentation during the acute course of a common cold. It seems reasonable, however, that an acutely inflamed and sensitive respiratory mucous membrane should be treated with the same tender consideration as are acute infections elsewhere in the body and that strong astringents and instrumental investigation are usually little more than damaging to already injured tissues. Dr. Arlie Bock has shown very excellent results in treating upper respiratory tract infections of Harvard students in Stillman Infirmary when no astringent sprays and drops are used and no instrumentation of the upper respiratory tract is allowed in the acute stages.

But Dr. Richards is to be complimented on presenting so interesting and complete a thesis on the ear, nose and throat. One has the conviction in reading this book that none of it has been written before. The tempo of its originality is set, at a casual glance, by the originality

of its illustrations, drawn for the most part by the author. This book should fill an important place not only in the library of the general practitioner but of all those interested in the science and the art of treatment, and in the care of the patient.

THEODORE L. BADGER, M.D. '26

VIRUS AND RICKETTSIAL DISEASES. With Especial Consideration of Their Public Health Significance. Harvard School of Public Health Symposium. Volume 2. ix + 907 pp. Cambridge: Harvard University Press. 1940. \$6.50.

Knowledge of infectious diseases has a long history. From a very early period in man's development has come a recognition of the clinical picture of infectious diseases and of their communicability, in some manner, from man to man. As time went on, there developed an ever increasing and an ever more satisfactory knowledge of their symptomatology, and even of their epidemiology. Their cause, however, remained almost unknown until the commencement of the ninth decade of the nineteenth century, when with a rush came elucidation of the etiology of a large group of the infectious diseases—namely, those due to bacteria. By the commencement of the twentieth century the majority of the bacterial diseases had a known etiology, and we had a satisfactory basis for the treatment of numerous infectious diseases and for the satisfactory control of some. At first rapidly, and latterly more slowly, investigation as to etiology, epidemiology, symptomatology, and treatment of bacterial diseases has been consolidated into an efficient methodology of practice.

Many infectious diseases, however, remained in the group of those of "unknown etiology," and this handicapped epidemiology and prevented a really intelligent approach to prevention and therapy. For numerous members of this group of communicable diseases of unknown cause an almost perfect natural protection against recurrent attacks was recognized, and for a very long time satisfactory protective immunization had been practiced in the case of at least one of these—vaccination against smallpox. But lack of knowledge of their cause, except that they were not of bacterial etiology, prevented further progress in prevention and therapy. Then with another rush, chiefly in the present decade, is coming better understanding of the filter-passing or virus causes of disease, and new methods of study have become available to aid in solving numerous of the very many uncertainties about infectious diseases.

The new or virus era is so recent, and investigation is so active, that a very extensive present knowledge is not satisfactorily accessible to physicians, almost all of whom in their practice

come frequently in contact with infectious diseases of virus etiology or with diseases caused by microorganisms intermediate between viruses and bacteria—namely, the rickettsiae. Realizing this, the Faculty of the Harvard School of Public Health planned a symposium in June, 1939, to bring together present knowledge of this group of communicable diseases. The lectures given then are presented in the volume now under review.

It is a satisfaction to Harvard men to find that this School, with the closely affiliated Harvard Medical School, have in their teaching forces men capable of presenting almost all of this new knowledge from the view-point of those who were working directly on the problems in question. In this volume there is an assembly of fact and data, as now known, of non-bacterially-caused infectious diseases scarcely obtainable anywhere else. This is of great interest and practical usefulness to practitioners, epidemiologists, public health officers, and laboratory investigators in the general fields of bacteriology and pathology. To all of these the reviewer very enthusiastically commends "Virus and Rickettsial Diseases."

In this volume first appears a group of chapters describing features common to the virus and the rickettsial diseases, chapters filled with new and fascinating facts, as follows: *Epidemiologic Problems in Virus Diseases* by John E. Gordon, *Insects as Vectors of Virus Diseases* by Lieut. Col. James S. Simmons, *Immunology of Infections by Filtrable Virus Agents* by Hans Zinsser, and *Physical and Chemical Properties of Filtrable Viruses* by J. Howard Mueller. Then comes a series of papers—equally interesting—on variola and vaccinia: *Epidemiology and Control of Variola* by Frederick F. Russell, *Methods of Preparation and Use of Vaccine Virus* by Elliott S. Robinson, *Generalized Vaccinia* by Ralph A. Ross, and *Neurologic Complications of Vaccination* by R. Cannon Eley. These are followed by chapters on measles and mumps: *Etiology of Measles* by John F. Enders, *Prevention and Modification of Measles* by Charles F. McKhann, *Study of Factors that Influence Reporting of Measles* by Harold D. Choep, and *Mumps, Its Glandular and Neurologic Manifestations* by Conrad Wesselhoef. The topic, virus diseases of the respiratory tract, is preceded by two enlightening general discussions: *Absorption of Toxic and Infectious Material from the Respiratory Tract* by Cecil K. Drinker and *General Considerations of Virus Diseases of the Respiratory Tract* by John R. Mote, followed by *Distemper in Animals* by Lieut. Col. Raymond A. Kelser, *Human and Swine Influenzas* by John R. Mote, and *Psittacosis* by John F. Enders.

In subsequent chapters Nels A. Nelson treats of *Lymphogranuloma Inguinale*; W. Lloyd Aycock of the *Epidemiology of Poliomyelitis*; and *A Review of Preventive Measures*; Charles F. Mc-

Khann of *Clinical Features and Treatment of Poliomyelitis*; LeRoy D. Fothergill of a *Tentative Classification of Virus Diseases of the Central Nervous System, with a Consideration of Certain Epidemic Types of Encephalitis*; of *Equine Encephalomyelitis*; and of *Louping Ill*; Lieut. Col. Raymond F. Kelser of the *Epidemiology and Prophylaxis of Rabies*; Kenneth D. Blackfan of *Lymphocytic Choriomeningitis*; and Lieut. Col. James S. Simmons of *Dengue Fever*.

In three more chapters yellow fever is discussed as to etiology, epidemiology, and preventive vaccination by A. Watson Sellards, Frederick F. Russell, and John E. Gordon, while in the four final chapters S. Burt Wolbach, Henry Pinkerton, John E. Gordon, and Hans Zinsser give a general survey and discuss the diagnosis, clinical classification, clinical features, epidemiology, and immunity in rickettsial diseases.

The subjects, as just given, of the chapters in this book epitomize the content, and indicate what the reader may expect in the way of information obtained from reading it. With two or three exceptions—and these former students—all of the authors have been an integral part of teaching at Harvard, and all are well known to the medical world by reason of their investigations.

Space is not available to discuss in detail individual chapters, notwithstanding the wealth of interest packed into them. It is noteworthy that the longest chapter of the book concerns the influenzas. The reasons for this perhaps are two: (1) Along with the common cold in frequency of occurrence and brevity of post-attack immunity influenza is one of our greatest economic health evils; (2) clear-cut final knowledge of the detailed etiology of influenza is lacking, and of prevention we know nearly nil. "In the absence of more complete and specific etiologic information concerning respiratory virus infections, it is evident that a public health effort at specific prevention in this group of diseases is both premature and unwise" (Mote). "... the possibility that influenza of man and lower animals, and the thing we call distemper, are all much more closely related etiologically than some of us may readily admit..." "... it seems to me that in the light of alterations which can be made in the disease-producing characteristics and immunologic responses of certain viruses, under different environments, the suggestion that the causal agents of the influenzas and distemper may have originated from a single stem is by no means fantastic" (Kelser). These words indicate one reason why many of the problems of virus diseases remain as yet incompletely solved.

Of poliomyelitis, about which gathers so great a sentimental interest, actually out of proportion to the seriousness of the disease, we learn happily that, "The regularity with which immunity is found in different populations, irrespective of previous occurrence of the paralytic

disease, indicates that the dissemination of the virus is widespread and more or less uniform in character, while the paralytic disease is the exceptional, variable, and selective outcome of exposure to the infectious agent" (Aycock). Still is it true that "there is confusion when an attempt is made to formulate a generally acceptable concept of poliomyelitis as a public health problem" (Aycock); and "Suffice it here, in summary, to say that in spite of the world-wide intensive research against it, poliomyelitis remains a disease of which adequate information regarding the prevention and specific treatment is lacking" (McKhann). As to prevention, "Serum therapy and passive immunization . . . have not met with success in the experimental disease. Active immunization . . . has proved neither safe nor sufficiently efficacious for practical use . . . Chemical blockade of the upper respiratory mucosa is the procedure which experimentally offers most promise; but in actual trials it has not proved successful" (Aycock).

These scattered quotations should serve to whet the appetite of prospective readers for more of the authoritative information contained in this volume. Harvard men rightly can feel pride in this book from their School of Public Health. It is well presented from the angle of book-making by the Harvard University Press. The reviewer has enjoyed it, and from it has learned much of great interest to him; other readers without doubt will have the same experience.

HENRY A. CHRISTIAN,
Hersey Professor of the Theory
and Practice of Physic, *Emeritus*.

HEALTH AT FIFTY. Edited by William H. Robey, M.D. '95. 299 pp. Harvard University Press, Cambridge, 1939. Price \$3.

This volume consists of twelve lectures selected from the Sunday afternoon public lecture courses given by the faculty of the Harvard Medical School in recent years. With increasing interest on the part of intelligent laymen in the structure and function of the human body in health and disease, it is well to have such a clear and scientifically accurate elucidation of some important health problems presented by recognized authorities. The subjects selected are quite diverse, each treated in a separate chapter by a well known expert. Every reader should find a special interest in some one or other of them. Space does not permit more than the briefest comment on each.

Dr. Herriman L. Blumgart's and Dr. Soma Weiss's related articles on "Heart Disease" and "Blood Pressure—Low and High" respectively, should go far in dispelling some of the fog and fear which envelops these subjects in the public mind.

The engrossing subject of "Underweight and Overweight" is sanely discussed by Dr. F. Dennette Adams, and the mystery of the calories clearly explained.

The cancer problem is admirably presented by Dr. William T. Salter. The results of the enormous volume of recent research work are extremely well epitomized. The hopeful results of present day treatment in early cases are recorded, and an earnest plea is made for still further and deeper organized research in this colossal problem.

That protean affliction designated under the term "Rheumatism" is ably discussed by Dr. Walter Bauer. The tremendous social and economic significance of this disease is emphasized and the need of continuing research is stressed. Dr. Bauer's classification of the various types of arthritis is simple and rational. The treatment outlined for the various types of disease, while distinctly helpful in many cases, still leaves much to be desired.

At first sight it might seem that undue space was allotted to the subject of "Menstruation" and its abnormalities. But after all half of our adult population either is or has been intimately concerned with this phenomenon, which is here clearly explained by Dr. John Rock, in the light of recent biological discoveries. The author has a light touch especially appropriate perhaps in dealing with so delicate a subject. The diagrams accompanying the article seem somewhat complicated and obscure for the average lay man or woman.

There is a chapter on the "Care of the Eyes" by Dr. T. L. Terry. The phenomena of vision and the principles of optics are demonstrated with the help of excellent diagrams. The more important diseases of the eye are described and some excellent advice given.

One of the most interesting chapters in the book is by Dr. S. Burt Wolbach who tells the fascinating and dramatic story of the "Vitamins" with skill founded on sound knowledge.

The difficult assignment of elucidating to the laity the functions of the "Glands of Internal Secretion" is undertaken most creditably by Dr. Joseph C. Aub.

Dr. Reginald Fitz in an article in a lighter vein reduces the contents of the "Family Medicine Cabinet" to very simple numbers. (His surgical colleagues might even suggest further elimination).

"Social Stress and Mental Health" is disposed by Dr. C. Macfie Campbell. The author explains that his subject matter cannot be treated with the precision and exact measurement so dear to the scientist in laboratory investigation. It must be said, however, that Dr. Campbell is extremely skillful in presenting his meaning with verbal precision, force and clarity. It is an impressive, wise and thoughtful essay.

The last chapter in the book by the editor, Dr. William H. Robey, entitled "Preparing for a Comfortable Old Age" contains much wisdom and sound sense combined with a sunny philosophy.

In several chapters great stress is laid on the remarkable prolongation of the expectancy of life, which has been attained in recent years as the result of medical progress. This notable and gratifying achievement has been brought about very largely, however, by a marked decrease in infant mortality, as a result of progress in the prevention and treatment of the diseases of early life. Some authorities maintain that there has been little or no prolongation of life expectancy, during the last twenty-five years, in persons of adult age. It would be unfortunate if the gentle reader, who is presumably of adult age, should infer exaggerated expectations of personal longevity from emphasis placed upon the prolongation of life expectancy at birth.

One or two of the essays in this volume seem to show that scientific men, accustomed to the utmost accuracy and precision in the laboratory, are not entirely free from some obscurity and confusion of expression in wielding the pen. This, however, is understandable owing to the inherent difficulty of putting scientific data into every day language. The book is a real achievement containing much reliable information and good advice of great value to the general public and to many practising physicians.

LINCOLN DAVIS, '98

ATLAS OF SURGICAL OPERATIONS, by Elliott C. Cutler, '13, and Robert Zollinger. Illustrated by Mildred B. Coddington. 181 pp., 84 plates. The MacMillan Company, New York. September, 1939. Price \$8.50.

The authors of this excellent book dedicate their efforts to the internes, assistant residents and residents of the Lakeside and Brigham Hospitals "whose struggles to acquire a safe surgical technique have been the stimulus for this Atlas." The book is intended to stand between a student textbook and an exhaustive treatise on operative surgery. It is inevitable, however, that it will be seized upon by medical students, practitioners and all medical folk reviewing for examinations.

The volume is about 11 x 15 inches in size and weighs 3½ pounds. It is printed on good paper and nicely bound in cloth. Each of the 84 plates contains six to twelve drawings and is accompanied by an explanatory text. The book begins with three general chapters on surgical technique, anesthesia and pre-operative and post-operative care.

The most important thing about a picture book is the pictures, and Cutler and Zollinger have never allowed themselves to forget this fact. The

drawings by Miss Coddington have been done with great accuracy and skill and the technical details are presented with the fidelity of an engineer's blueprint. For example when a clamp is included in a picture, the particular instrument may be recognized at a glance. This may seem a small point but it is a feature which other medical artists might well adopt. The details of special stitches are shown with the same accuracy. Another good feature is the use of a separate diagrammatic insert to show the completed operation in various gastro-intestinal anastomoses.

Some people prefer half-tones to pen and ink drawings and the reviewer has heard this comment made about the Atlas. There is no doubt that half-tones are more beautiful to look upon but there are some important practical points which must be kept in mind. In order successfully to reproduce half-tones much more expensive processing is necessary and more expensive paper must be used. This would increase the cost of the volume about 2½ times and consequently carry it out of the price range for the group which it is intended to serve.

One speculates on the nature of the collaboration of the two men and a woman who produced such an exhaustive work. The authors give some clue in their preface. "This is a small book and a chief part of its value lies in the illustrations, which are from the pen of Miss Mildred Coddington. She has survived the innumerable corrections over a long period of time with an almost saintly disposition." Knowing the authors this last seems a fine bit of understatement. In all seriousness, however, the production of the Atlas must have been a back-breaking piece of work and its freedom from errors is a great tribute to the authors. Anyone who has ever struggled over the illustrations of one small article will wonder at the pertinacity with which the book was completed.

The authors lay no claim to any original surgical procedures. They have selected standard operations and presented them with such clarity and detail that one can review an operation in a very few moments. The material presented covers the field of general surgery and gynecology. It is noteworthy that neither cranial nor cardiac surgery are included. Particular stress is laid throughout the book on the principals of surgery introduced by Halsted. The importance of gentleness in handling tissues, delicacy of technique and the use of fine suture material is repeatedly emphasized. They make it clear that asepsis, proper anesthesia, and adequate hemostasis are far more important than speed or sheer virtuosity of technique. No special instruments are needed for performing any of the operations, with the possible exception of a "bobbie-pin." (See Plate LI.)

Some of the descriptions will be particularly useful to medical students. The section on the

repair of herniae should do much to clarify the confusion existing in the average student's mind on this subject. It is refreshing to find that no mention is made of the layers of the sac in inguinal herniae. At least in one instance medical education has been simplified.

The plates describing gastro-intestinal surgery are extremely helpful. Whereas students are no longer held responsible for the intricacies of operative technique, it should be possible to become familiar with the different types of gastric resections and anastomoses in a short time.

There is little to quarrel about in the authors' choice of operative procedures although one wonders why they advocate an open anastomosis in a large bowel surgery. To be sure the Parker-Kerr technique is mentioned in the text but for some reason is neither illustrated nor particularly stressed.

Although any bibliography has been deliberately omitted it would seem quite worth while in future editions to mention a few good papers in connection with each type of operation to help the student to find further information if he so desired. It might be desirable to point out the value of animal experimentation, particularly in gastro-intestinal surgery. This was a point upon which Dr. Halsted always was insistent. In one of his last papers he expressed the opinion that no one should undertake intestinal anastomoses without first perfecting his technique on dogs.

It is interesting to note the frequency with which avertin anesthesia is mentioned throughout the book. One would judge that this anesthetic is more widely used at the Brigham than at other hospitals.

The book makes no pretense of being a text book of surgery yet it would seem that a little space in the text could have been devoted to the subject of blood chemistry in the pre-operative and post-operative care of patients. In view of the fact that surgery has made more rapid advances in this particular field than in almost any other within recent years, it might be well to make the student of surgery realize its importance.

As a whole there is much to praise and little to blame in the Atlas. The authors suggest in their introduction that they intend to add more plates in future editions. If the book is a successful as it has every right to be, new editions will be forthcoming before long. It will be a valuable contribution to the library of every young surgeon.

STEPHEN J. MADDOCK, '25

COURSES FOR GRADUATES

Harvard Medical School

This Department of the Harvard Medical School has organized three new, restricted one-year courses in Internal Medicine: one at the Massachusetts General Hospital under the direction of Dr. James H. Means; one at the Peter Bent Brigham Hospital under the direction of Dr. Soma Weiss; and one at the Boston City Hospital under the direction of Dr. George R. Minot, Dr. Laurence B. Ellis, and Dr. W. Richard Ohler.

For further information apply to Assistant Dean, Courses for Graduates, Harvard Medical School, Boston, Massachusetts.

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- Photography
- Pianist
- Reading to Invalid
- Reporter for Journals
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- Student House Officer
- Subject for Experiments
- Switchboard Operator
- Translation (any language)
- Tutor (any subject, any sport)
- Typing

Geographical Distribution of Harvard Medical School

GRADUATES

PACIFIC STATES	
California	228
Oregon	37
Washington	44
Total	309

NEW ENGLAND	
Maine	79
New Hampshire	75
Vermont	16
Massachusetts	1883
Rhode Island	150
Connecticut	230
Total	2433

MIDDLE ATLANTIC	
New York	495
New Jersey	65
Pennsylvania	119
Total	679

SOUTH ATLANTIC	
Delaware	3
Maryland	28
District of Columbia	36
Virginia	17
West Virginia	18
North Carolina	34
South Carolina	5
Georgia	15
Florida	27
Total	862

EAST NORTH CENTRAL	
Ohio	110
Indiana	15
Illinois	73
Michigan	63
Wisconsin	44
Total	305

EAST SOUTH CENTRAL

Kentucky	18
Tennessee	16
Alabama	22
Mississippi	1
Total	57

WEST SOUTH CENTRAL

Arkansas	3
Louisiana	8
Oklahoma	11
Texas	35
Total	57

WEST NORTH CENTRAL

Minnesota	15
Iowa	15
Missouri	45
North Dakota	2
South Dakota	3
Nebraska	16
Kansas	13
Total	109

MOUNTAIN

Montana	5
Idaho	6
Wyoming	4
Colorado	36
New Mexico	5
Arizona	8
Utah	18
Nevada	2
Total	84

ALASKA, CANADA AND FOREIGN

Alaska	
Canada	20
Foreign	76
Total	96

Total—4,312

NECROLOGY

'70—FREDERICK HENRY THOMPSON died at Fitchburg, Mass., December 14, 1939.

'84—CLEMENT WILLIS SPARHAWK died at Watertown, Mass., October 22, 1939.

'85—GEORGE EMERSON died at New York City, December 24, 1939.

'85—WALTER LEE MUNRO died at Providence, R. I., October 23, 1939.

'86-89—GEORGE ALBERT MORRILL died at Groton, Mass., December 22, 1939.

'87—HENRY BARTON JACOBS died at Baltimore, Md., December 18, 1939.

'91-93—HARRY ALBERTUS BROWN died at Whitinsville, Mass., May 7, 1939.

'94—WILLIAM BURDETT BATCHELDER died at Boston, Mass., November 9, 1939.

'95-99—CHARLES HAROLD WALLING died at Nantucket, Mass., August 9, 1937.

'98—ALBERT EDWIN HAYES, died at Putnam, Conn., October 26, 1939.

'98—FREDERIC JOSEPH PEIRCE died at Pueblo, Colo., November 15, 1939.

'01—REES BYRON REES died at Bakersfield, Calif., August 19, 1939.

'03—CHARLES MOLINE died at Sunderland, Mass., November 15, 1939.

'04—CHARLES ARTHUR OAK died at Lynn, Mass., Novemberth 15, 1939.

'05—ROY SUMNER STEARNS died December 12, 1939.

'08—THEODORE MILLER died at Cleveland, Ohio, November 7, 1939.

'25—SUMNER MEAD ROBERTS died at Hyannis, Mass., November 19, 1939.

'25—CHARLES RUSSELL WEAVER died at Portland, Ore., September 7, 1939.

'25-26—STEPHEN ROSSON LESHER died at New York, N. Y., February 28, 1939.

'33—DONALD STEVENS ADAMS died at Los Angeles, Calif., December 4, 1939.

'33—SMITH OWEN DEXTER, Jr., died at Annapolis, Md., November 25, 1939.

ALUMNI NOTES

'94—Frederic W. Pearl has been commissioned Medical Director and Colonel, United States Public Health Service, attached to the American Embassy, Grosvenor Square, London.

'95—The late Harvey W. Cushing, who died on October 7, 1939, bequeathed his large medical historical library to Yale University, and made provision that one-third of the residue of his estate should accompany the library bequest. In addition, he made a bequest of \$10,000 for John J. Fulton, '27, Sterling Professor of Physiology at Yale, to enable him to carry on biographical studies and library cataloguing at the Yale library.

'96—James T. Fisher, former professor of medicine at the Medical Department, University of Southern California, has moved to Laguna Beach, Calif.

'96—David Townsend has been made a "Fellow of the American College of Chest Physicians." This is the second honor which he has recently received in recognition of his work in his chosen field, tuberculosis. Both of which came to him unsolicited.

'96—Frederic A. Washburn, formerly director of the Massachusetts General Hospital, is vice-chairman of the public information advisory committee of the Massachusetts Hospital Association.

'99—Robert B. Osgood, John Ball and Buckminster Brown Professor of Orthopaedic Surgery, *Emeritus*, at the Harvard Medical School, has been reappointed by Gov. Saltonstall a trustee of the Massachusetts Hospital School.

'01—Harold W. Smith writes that he is still a rear-admiral in the medical corps of the Navy, and currently in command of the Naval Medical Center, at Washington, D. C.

'02—A scientific paper written by George D. Scott entitled "Factors in Infant Mortality" will appear as a serial in the *Medical World* in January and February of this year.

'03—George E. Deering's son, George E. Deering, Jr., is in the first year class at the Harvard Medical School.

'03—William H. Walker writes that he is still assistant superintendent at the Fairfield State Hospital, Newtown, Conn.

'08—C. Guy Lane, lecturer on dermatology at the Harvard Medical School has been promoted to clinical professor of dermatology.

'08—Michael A. Tighe's son Thomas J. G. Tighe, '40, is "the first repeat of the class of 1908."

'09—F. Gordon Brigham has been reappointed as physician-in-chief of the New England Deaconess Hospital and the Palmer Memorial Hospital of Boston.

'12—Lewis W. Hackett who represents the International Health Division of the Rockefeller Foundation in the Mediterranean region, has moved his office and residence from Rome, Italy to Egypt. His address is the Public Health Laboratories, Cairo.

'12—George R. Minot gave the Gordon Wilson Lecture of the American Clinical and Climatological Association at Saranac Lake, N. Y., on October 10, 1939, and on that occasion received the Gordon Wilson Medal of the Association. In December, 1939, Minot was elected "Membre honoraire étranger" of the Academie Royale de Medecine de Belgique.

'12—Francis M. Rackemann, associate in medicine at the Harvard Medical School, has been elected secretary-treasurer of the American Clinical and Climatological Association.

'12—McIver Woody, head of the medical de-

